3380L.02C

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1304

AN ACT

To repeal sections 379.316, 383.150, 538.210 and 538.225, RSMo, and to enact in lieu thereof twenty-nine new sections relating to medical malpractice liability insurance, with an emergency clause.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 379.316, 383.150, 538.210 and 538.225, RSMo, are repealed and twenty-nine new sections enacted in lieu thereof, to be known as sections 135.163, 379.316, 383.112, 383.150, 383.151, 383.200, 383.205, 383.210, 383.215, 383.220, 383.225, 383.230, 383.600, 383.610, 383.615, 383.620, 383.625, 383.630, 383.635, 383.640, 383.645, 383.650, 383.655, 537.072, 538.210, 538.211, 538.225, 538.226, and 1, to read as follows:

135.163. 1. For all tax years beginning on or after January 1, 2005, in order to encourage the retention of physicians and other health care providers in this state, an eligible taxpayer shall be allowed a credit not to exceed fifteen thousand dollars per eligible taxpayer against the tax otherwise due pursuant to chapter 143, RSMo, not including sections 143.191 to 143.265, RSMo, in an amount equal to fifteen percent of the increase in amount paid by an eligible taxpayer for medical

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in boldface type in the above law is proposed language.

malpractice insurance premiums in the aggregate from one policy period to the next immediate policy period. For purposes of this section, the base policy period for calculation of the credit shall be the medical malpractice insurance policy in effect on August 28, 2004.

2. The tax credit allowed by this section shall be claimed by the taxpayer at the time such taxpayer files a return. Any amount of tax credit which exceeds the tax due shall be carried over to any of the next five subsequent taxable years, but shall not be refunded and shall not be transferable.

3. The director of the department of insurance and the director of the department of revenue shall jointly administer the tax credit authorized by this section. The director of the department of insurance shall enact procedures to verify the amount of the allowable credit and shall issue a certificate to each eligible taxpayer that certifies the amount of the allowable credit. Both the director of the department of insurance and the director of the department of revenue are authorized to promulgate rules and regulations necessary to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are

nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

4. The tax credits issued pursuant to this section shall not exceed a total for all tax credits issued of fifteen million dollars per fiscal year.

379.316. 1. Section 379.017 and sections 379.316 to 379.361 apply to insurance companies incorporated pursuant to sections 379.035 to 379.355, section 379.080, sections 379.060 to 379.075, sections 379.085 to 379.095, sections 379.205 to 379.310, and to insurance companies of a similar type incorporated pursuant to the laws of any other state of the United States, and alien insurers licensed to do business in this state, which transact fire and allied lines, marine and inland marine insurance, to any and all combinations of the foregoing or parts thereof, and to the combination of fire insurance with other types of insurance within one policy form at a single premium, on risks or operations in this state, except:

(1) Reinsurance, other than joint reinsurance to the extent stated in section 379.331;

(2) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks

commonly insured pursuant to marine, as distinguished from inland marine, insurance policies;

(3) Insurance against loss or damage to aircraft;

(4) All forms of motor vehicle insurance; and

(5) All forms of life, accident and health, **[**and**]** workers' compensation insurance, and medical malpractice liability insurance.

2. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the director, or as established by general custom of the business, as inland marine insurance.

3. Commercial property and commercial casualty insurance policies are subject to rate and form filing requirements as provided in section 379.321.

383.112. Any insurer or self-insured health care provider that fails to timely report claims information as required by sections 383.100 to 383.125 shall be subject to the provisions of section 374.215, RSMo.

383.150. As used in sections 383.150 to 383.195, the following terms shall mean:

(1) "Association" **[**means**]**, the joint underwriting association established pursuant to the provisions of sections 383.150 to 383.195;

(2) "Competitive bidding process", a process under which

the director seeks, and insurers may submit, rates at which insurers guarantee to provide medical malpractice liability insurance to any health care provider unable to obtain such insurance in the voluntary market;

(3) "Director" [means], the director of the department of insurance;

[(3)] (4) "Health care provider" includes physicians, dentists, clinical psychologists, pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors, physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals, nursing homes and extended care facilities; but shall not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination;

[(4)] (5) "Medical malpractice insurance" [means], insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of the negligence or malpractice in rendering professional service by any health care provider;

[(5)] (6) "Net direct premiums" [means], gross direct premiums written on casualty insurance in the state of Missouri by companies authorized to write casualty insurance under chapter

379, RSMo 1969, in the state of Missouri, less return premiums thereon and dividends paid or credited to policyholders on such direct business.

383.151. When the department determines after a public hearing that medical malpractice liability insurance is not reasonably available for health care providers in the voluntary market, the director shall establish a method for providing such insurance to such health care providers. The director may:

(1) Establish a competitive bidding process under which insurers may submit rates at which they agree to insure such health care providers; or

(2) Establish any other method reasonably designed to provide insurance to such health care providers.

383.200. 1. As used in sections 383.200 to 383.225, the following terms mean:

(1) "Director", the same meaning as such term is defined in section 383.100;

(2) "Health care provider", the same meaning as such term is defined in section 383.100;

(3) "Insurer", an insurance company licensed in this state to write liability insurance, as described in section 379.010, RSMo;

(4) "Medical malpractice insurance", the same meaning as such term is defined in section 383.200.

2. The following standards and procedures shall apply to

the making and use of rates pertaining to all classes of medical malpractice insurance:

(1) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate is excessive if it is unreasonably high for the insurance provided. A rate is inadequate if it is unreasonably low for the insurance provided and continued use of it would endanger the solvency of the company. A rate is unfairly discriminatory if it does not reflect equitably differences in reasonably expected losses and expenses;

(2) (a) Every insurer that desires to increase a rate by less than fifteen percent shall file such rate, along with data supporting the rate change as prescribed by the director, no later than thirty days after such rate becomes effective. Filings under this paragraph shall not be subject to approval or disapproval by the director.

(b) Every insurer that desires to increase a rate by fifteen percent or more shall submit a complete rate application to the director. A complete rate application shall include all data supporting the proposed rate and such other information as the director may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this act.

(c) Every insurer that has filed a rate increase under paragraph (a) of this subdivision for two consecutive years and in the third year desires to file a rate increase which in the

aggregate over the three-year period will equal or exceed a total rate increase of forty percent or more shall be required to submit a complete rate application under paragraph (b) of this subdivision.

(d) Every insurer that has not filed or had a rate increase approved for three consecutive years may file a rate increase in the fourth year in an amount not to exceed a twenty-five percent increase without being required to submit a complete rate application under paragraph (b) of this subdivision;

(3) The director of insurance shall promulgate rules setting forth standards that insurers shall adhere to in calculating their rates. Such rules shall:

(a) Establish a range within which an expected rate of return shall be presumed reasonable;

(b) Establish a range within which categories of expenses shall be presumed reasonable;

(c) Establish a range for the number of years of experience an insurer may consider in determining an appropriate loss development factor;

(d) Establish a range for the number of years of experience an insurer may consider in determining an appropriate trend factor;

(e) Establish a range for the number of years of experience an insurer may consider in determining an appropriate increased limits factor;

(f) Establish the proper weights to be given to different years of experience;

(g) Establish the extent to which an insurer may apply its subjective judgment in projecting past cost data into the future;

(h) Establish any other standard deemed reasonable and appropriate by the director;

(4) The director shall require an insurer to submit with any rate change application:

(a) A comparison, in a form prescribed by the director, between the insurer's initial projected incurred losses and its ultimate incurred losses for the eight most recent policy years for which such data is available;

(b) A memorandum explaining the methodology the insurer has used to reflect the total investment income it reasonably expects to earn on all its assets during the period the proposed rate is to be in effect. The director shall disapprove any rate application that does not fully reflect all such income;

(5) The director shall notify the public of any application from an insurer seeking a rate increase of fifteen percent or more, and shall hold a hearing on such application within forty-five days of such notice. The application shall be deemed approved ninety days after such notice unless it is disapproved by the director after the hearing;

(6) If after a hearing the director finds any rate of an insurer to be excessive, the director may order that the insurer

discontinue the use of the rate and that the insurer refund the excessive portion of the rate to any policyholder who has paid such rate. The director shall not be required to find that a reasonable degree of competition does not exist to find a rate excessive.

3. For insurers required to file pursuant to paragraph (b) of subdivision (2) of subsection 2 of this section, if there is insufficient experience within the state of Missouri upon which a rate can be based with respect to the classification to which such rate is applicable, the director may approve a rate increase that considers experiences within any other state or states which have a similar cost of claim and frequency of claim experience as this state. If there is insufficient experience within Missouri or any other states which have similar cost of claim and frequency of claim experience as Missouri, nationwide experience may be considered. The insurer in its rate increase filing shall expressly show the rate experience it is using.

4. All information provided to the director under this section shall be available for public inspection.

5. The remedies set forth in this chapter shall be in addition to any other remedies available under statutory or common law.

6. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it

complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

383.205. For all medical malpractice insurance policies written for insureds in the state of Missouri, the ratio between the base rate of the highest-rated specialty and the base rate of the lowest-rated specialty shall be no more than a ratio of six-to-one.

383.210. In determining the premium paid by any health care provider, a medical malpractice insurer shall apply a credit or debit based on the provider's loss experience, or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer shall include a schedule of all such credits and debits, or a description of such alternative method in all filings it makes with the director of insurance. No medical malpractice insurer may use any rate or charge any premiums unless it has filed such schedule or alternative method with the director of insurance and the director has approved such schedule or alternative method. A debit shall be based only on those claims that have been paid on behalf of the provider.

383.215. On or before March first of each year, every insurer providing medical malpractice insurance to a health care provider shall file the following information with the director of insurance:

(1) Information on closed claims:

(a) The number of new claims reported during the preceding calendar year, and the total amounts of reserve for such claims and for allocated loss adjustment expenses in connection with such claims;

(b) The number of claims closed during the preceding year, and the amount paid on such claims, detailed as follows:

a. The number of claims closed each year with payment, and the amount paid on such claims and on allocated loss adjustment expenses in connection with such claims;

b. The number of claims closed each year without payment, and the amount of allocated loss adjustment expenses in connection with such claims;

(2) Information regarding judgments, payment, and severity of injury in connection with judgements:

(a) For each judgment rendered against an insurer for more than one hundred thousand:

a. The amount of the judgment and the amount actually paid to the plaintiff;

b. The category of injury suffered by the plaintiff. Injuries shall be categorized as follows:

Category 1: Temporary injury, emotional only.

Category 2: Temporary insignificant injury, including lacerations, contusions, minor scars, and rash.

Category 3: Temporary minor injury, including infections, missed fractures, and falls in hospitals.

Category 4: Temporary major injury, including burns, left surgical material, drug side effects, and temporary brain damage.

Category 5: Permanent minor injury, including loss of fingers, and loss or damage to organs.

Category 6: Permanent significant injury, including deafness, loss of limb, loss of eye, and loss of one kidney or lung.

Category 7: Permanent major injury, including paraplegia, blindness, loss of two limbs, and brain damage.

Category 8: Permanent grave injury, including quadriplegia, severe brain damage, and any injury requiring lifelong care or having a fatal prognosis.

Category 9: Death;

(3) Information on each rate change implemented during the preceding five-year period by state and medical specialty;

(4) Information on premiums and losses by medical specialty:

(a) Written premiums and paid losses for the preceding year, and earned premiums and incurred losses for the preceding year, with specifics by medical specialty;

(b) Number of providers insured in each medical specialty;

(5) Information on premiums and losses by experience of the insured:

(a) Written premiums and paid losses for the preceding year, and earned premiums and incurred losses for the preceding year, with specifics as follows:

a. As to all insureds with no incidents within the preceding five-year period;

b. As to all insureds with one incident within the preceding five-year period;

c. As to all insureds with two incidents within the preceding five-year period;

d. As to all insureds with three or more incidents within the preceding five-year period;

(b) Number of providers insured:

a. With no incidents within the preceding five-year period;

b. With one incident within the preceding five-year period;

c. With two incidents within the preceding five-year period;

d. With three or more incidents within the preceding five-year period;

(6) Information on the performance of the investments of the insurer, including the value of the investments held in the portfolio of the insurer as of December thirty-first of the preceding calendar year, and the rate of return on such

investments, detailed by category of investment as follows:

(a) United States government bonds;

(b) Bonds exempt from federal taxation;

(c) Other unaffiliated bonds;

(d) Bonds of affiliates;

(e) Unaffiliated preferred stock;

(f) Preferred stock of affiliates;

(g) Unaffiliated common stock;

(h) Common stock of affiliates;

(i) Mortgage loans;

(j) Real estate; and

(k) Any additional categories of investments specified by the director of insurance.

383.220. 1. On or before July 1, 2005, and after consultation with the medical malpractice insurance industry, the director shall establish an interactive Internet site which will enable any health care provider licensed in this state to obtain a quote from each medical malpractice insurer licensed to write the type of coverage sought by the provider.

2. The Internet site shall enable health care providers to complete an online form that captures a comprehensive set of information sufficient to generate a quote for each insurer. The director shall develop transmission software components which allow such information to be formatted for delivery to each medical malpractice insurer based on the requirements of the

computer system of the insurer.

3. The director shall integrate the rating criteria of each insurer into its online form after consultation with each insurer using one of the following methods:

(1) Developing a customized interface with the insurer's own rating engine;

(2) Accessing a third-party rating engine of the insurer's choice;

(3) Loading the insurer's rating information into a rating engine operated by the director;

(4) Any other method agreed on between the director and the insurer.

4. After a health care provider completes the online form, the provider will be presented with quotes from each medical malpractice insurer licensed to write the coverage requested by the provider.

5. Quotes provided on the Internet site shall at all times be accurate. When an insurer changes its rates, such rate changes shall be implemented at the Internet site by the director, in consultation with the insurer, as soon as practicable but in no event later than ten days after such changes take effect. During any period in which an insurer has changed its rates but the director has not yet implemented such changed rates on the Internet site, quotes for that insurer shall not be obtainable at the Internet site.

6. The director shall design the Internet site to incorporate user-friendly formats and self-help guideline materials, and shall develop a user-friendly Internet user-interface.

7. The Internet site shall also provide contact information, including address and telephone number, for each medical malpractice insurer for which a provider obtains a quote at the Internet site.

8. By December 31, 2005, the director shall submit a report to the general assembly on the development, implementation, and affects of the Internet site established by this section. The report shall be based on:

(1) The director's consultation with health care providers, medical malpractice insurers, and other interested parties; and

(2) The director's analysis of other information available to the director, including a description of the director's views concerning the extent to which the information provided through the Internet site has contributed to increasing the availability of medical malpractice insurance and the effect the Internet site has had on the cost of medical malpractice insurance.

383.225. Each insurer shall file with the director of insurance new manuals of classifications, rules, underwriting rules, rates, rate plans and modifications, policy forms and other forms to which such rates are applied, that reflect the savings, if any, attributable to each provision of this act.

383.230. Insurers writing medical malpractice insurance shall provide insured health care providers with written notice of any increase in renewal premium rates at least ninety days prior to the date of the renewal. At a minimum, the notice shall be sent by first class mail at least ninety days prior to the date of renewal and shall contain the insured's name, the policy number for the coverage being renewed, the total premium amount being charged for the current policy term, and the total premium amount being charged to renew the coverage.

383.600. 1. Sections 383.600 to 383.655 shall be known as the "Missouri Physicians Mutual Insurance Company Act".

2. As used in sections 383.600 to 383.655 the following words mean:

(1) "Administrator", the chief executive officer of the Missouri physicians mutual insurance company;

(2) "Board", the board of directors of the Missouri physicians mutual insurance company;

(3) "Company", the Missouri physicians mutual insurance company.

383.610. The "Missouri Physicians Mutual Insurance Company" is created as an independent public corporation for the purpose of insuring Missouri physicians and their employees and their business against liability for professional negligence and other casualty losses. The company shall be organized and operated as a domestic mutual insurance company and it shall not be a state

agency. The company shall have the powers granted a general not-for-profit corporation pursuant to section 355.131, RSMo. The company shall be a member of the Missouri property and casualty guaranty association, sections 375.771 to 375.799, RSMo, and as such will be subject to assessments therefrom, and the members of such association shall bear responsibility in the event of the insolvency of the company. The company shall be established pursuant to the provisions of sections 383.600 to 383.655. The company shall use flexibility and experimentation in the development of types of polices and coverages offered to physicians and their employees, subject to the approval of the director of the department of insurance.

383.615. 1. There is hereby created a board of directors for the company. The board shall be appointed by January 1, 2005, and shall consist of nine members appointed or selected as provided in this section. The governor shall appoint the initial nine members of the board with the advice and consent of the senate. Each director shall serve a seven-year term. Terms shall be staggered so that no more than one director's term expires each year on the first day of July. The nine directors initially appointed by the governor shall determine their initial terms by lot. At the expiration of the term of any member of the board, the company's policy holders shall elect a new director in accordance with provisions determined by the board.

2. Any person may be a director who:

(1) Does not have any interest as a stockholder, employee, attorney, agent, broker, or contractor of an insurance entity who writes medical liability insurance, or whose affiliates write medical liability insurance;

(2) Is of good moral character and who has never pleaded guilty to, or been found guilty of a felony;

(3) Is not employed by or affiliated with, the state of Missouri, any hospital, health maintenance organization, or other entity providing any type of insurance in this state.

3. There shall be one member from each congressional district of the state. Further, two members shall be doctors of osteopathic medicine duly licensed to practice in the state of Missouri, three members shall be medical doctors licensed to practice in this state, one member shall be a nurse licensed to practice in this state, one member shall be an attorney licensed to practice by the Missouri supreme court, and one member shall have insurance experience.

4. The board shall annually elect a chairman and any other officers it deems necessary for the performance of its duties. Board committees and subcommittees may also be formed.

5. The company shall pay to the board members their expenses incurred in the business of the company or the board and a stipend in a sum set by the board, but not more than one thousand dollars per meeting or the board or committee or subcommittee thereof attended by the member.

383.620. 1. By January 1, 2005, the board shall hire an administrator who shall serve at the pleasure of the board and the company shall be fully prepared to be in operation by January 1, 2005, and assume its responsibilities by that date. The administrator shall receive compensation as established by the board and must have such qualifications as the board deems necessary. The administrator shall not be a physician.

2. The board is vested with full power, authority, and jurisdiction over the company. The board may perform all acts necessary or convenient in the administration of the company or in connection with the insurance business to be carried on by the company. In this regard, the board is empowered to function in all aspects as a governing body of a private insurance carrier.

383.625. 1. The administrator of the company shall act as the company's chief executive officer. The administrator shall be in charge of the day-to-day operations and management of the company.

2. Before entering the duties of office, the administrator shall give an official bond in an amount and with sureties approved by the board. The premium for the bond shall be paid by the company.

3. The administrator or the administrator's designee shall be the custodian of the moneys of the company and all premiums, deposits, or other moneys paid thereto shall be deposited with a financial institution as designated by the administrator.

4. No board member, officer, or employee of the company is liable in a private capacity for any act performed or obligation entered into when done in good faith, without intent to defraud, and in an official capacity in connection with the administration, management, or conduct of the company or affairs relating to it.

383.630. The board shall have full power and authority to establish rates to be charged by the company for insurance. The board shall contract for the services of or hire an independent actuary, a member in good standing with the American Academy of Actuaries, to develop and recommend actuarially sound rates. Rates shall be set at amounts sufficient, when invested, to carry all claims to maturity, meet the reasonable expenses of conducting the business of the company and maintain a reasonable surplus. The company shall conduct a program that shall be neither more nor less than self-supporting.

383.635. The board shall formulate and adopt an investment policy and supervise the investment activities of the company. The administrator may invest and reinvest the surplus or reserves of the company subject to the limitations imposed on domestic insurance companies by state law. The company may retain an independent investment counsel. The board shall periodically review and appraise the investment strategy being followed and the effectiveness of such services. Any investment counsel retained or hired shall periodically report to the board on

investment results and related matters.

383.640. Any insurance producer licensed to sell professional negligence insurance in this state shall be authorized to sell insurance policies for the company in compliance with the bylaws adopted by the company and upon the approval of the board. The board shall establish a schedule of commissions to pay for the services of the producer.

383.645. 1. The administrator shall formulate, implement, and monitor a program to decrease medical negligence by physicians and their staff for all policyholders.

2. The company shall have representatives whose sole purpose is to develop, with policyholders and the professional organizations related to the medical field, education and training seminars and other programs that provide training to physicians and their staffs.

3. The administrator or board may refuse to insure, or may terminate the insurance of any subscriber who refuses to attend such seminars or training or refuses to require their staff to attend such seminars or training as required by the board for its policyholders. The cost of said training seminars or a part thereof may be paid by the company.

383.650. 1. The company shall not receive any state appropriations, directly or indirectly, except as provided in this section.

2. After October 1, 2004, ten million dollars of the moneys

received from the master settlement agreement, as defined in section 196.1000, RSMo, shall be used to make loans for start-up funding and initial capitalization of the company. The state legislature shall place such moneys in a special fund under the supervision of the Missouri state treasurer called the "Physicians Mutual Insurance Company Loan Fund" in the appropriations for the appropriate fiscal year. The board of the company shall make application to the treasurer for the loans, stating the amount to be loaned to the company. The loans shall be for a term of ten years and, at the time the application for such loans is approved by the director, shall bear interest at the annual rate based on the rate for linked deposit loans as calculated by the state treasurer pursuant to section 30.758, RSMo.

3. In order to provide funds for the creation, continued development, and operation of the company, the board is authorized to issue revenue bonds from time to time, in a principal amount outstanding not to exceed fifty million dollars at any given time, payable solely from premiums received from insurance policies and other revenues generated by the company.

4. The board may issue bonds to refund other bonds issued pursuant to this section.

5. The bonds shall have a maturity of no more than ten years from the date of issuance. The board shall determine all other terms, covenants, and conditions of the bonds, except that

no bonds may be redeemed prior to maturity unless the company has established adequate reserves for the risks it has insured.

6. The bonds shall be executed with the manual or facsimile signature of the administrator or the chairman of the board and attested by another member of the board. The bonds may bear the seal, if any, of the company.

7. The proceeds of the bonds and the earnings of those proceeds shall be used by the board for the development and operation of the Missouri Physicians Mutual Insurance Company, to pay expenses incurred in the preparation, issuance, and sale of the bonds and to pay any obligations relating to the bonds and the proceeds of the bonds under the United States Internal Revenue Code of 1986, as amended.

8. The bonds may be sold at a public sale or a private sale. If the bonds are sold at a public sale, the notice of sale and other procedures for the sale shall be determined by the administrator or the company.

9. This section is full authority for the issuance and sale of the bonds and the bonds shall not be invalid for any irregularity or defect in the proceedings for their issuance and sale and shall be incontestable in the hands of bona fide purchasers or holders of the bonds for value.

10. An amount of money from the sources specified in subsection 3 of this section sufficient to pay the principal of and any interest on the bonds as they become due each year shall

be set aside and is hereby pledged for the payment of the principal and interest on the bonds.

11. The bonds shall be legal investment for any person or board charged with the investment of public funds and may be accepted as security for any deposit of public money, and the bonds and interest thereon are exempt from taxation by the state and any political subdivision or agency of the state.

12. The bonds shall be payable by the company, which shall keep a complete record relating to the payment of the bonds.

13. Not more than fifty percent of the bonds sold shall be sold to public entities.

383.655. 1. The board shall cause an annual audit of the books of accounts, funds, and securities of the company to be made by a competent and independent firm of certified public accountants, the cost of the audit to be charged against the company. A copy of the audit report shall be filed with the director of the department of insurance and the administrator. The audit shall be open to the public for inspection.

2. The board shall submit an annual independently audited report in accordance with the procedures governing annual reports adopted by the National Association of Insurance Commissioners by March first of each year and the report shall be delivered to the governor and the general assembly and shall indicate the business done by the company during the previous year and contain a statement of the resources and liabilities of the company.

3. The administrator shall annually submit to the board for its approval an estimated budget of the entire expense of administering the company for the succeeding calendar year having due regard to the business interests and contract obligations of the company.

4. The incurred loss experience and expense of the company shall be ascertained each year to include, but not be limited to, estimates of outstanding liabilities for claims reported to the company but not yet paid and liabilities for claims arising from injuries which have occurred but have not yet been reported to the company. If there is an excess of assets over liabilities, necessary reserves and a reasonable surplus for the catastrophe hazard, then a cash dividend may be declared or a credit allowed to an insured policyholder, who has been insured with the company in accordance with criteria approved by the board, which may account for insured's record and claims history.

5. The department of insurance shall conduct an examination for the company in the manner and under the conditions provided by the statutes of the insurance code for the examination of insurance carriers. The board shall pay the cost of the examination as an expense of the company. The company is subject to all provisions of the statutes which relate to private insurance carriers and to the jurisdiction of the department of insurance in the same manner as private insurance carriers, except as provided by the director.

6. For the purpose of ascertaining such information as the administrator may require in the proper administration of the company, the records of each policyholder and insured of the company shall be always open to inspection by the administrator or the administrator's duly authorized agent or representative.

7. Every person provided insurance coverage by the company, upon complying with the underwriting standards adopted by the company, and upon completing the application form prescribed by the company, shall be furnished with a policy showing the date on which the insurance becomes effective.

537.072. In all tort actions based upon improper health care, the parties shall make a good faith effort to engage in mediation, which shall be conducted by a trained mediator selected from a list approved by the circuit court. The parties shall advise the circuit court in writing that mediation take place. If mediation does not occur, the parties shall set forth in writing to the circuit court their good faith effort to conduct mediation.

538.210. 1. In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, no plaintiff shall recover more than three hundred fifty thousand dollars **[**per occurrence**]** for noneconomic damages from any one defendant as defendant is defined in subsection 2 of this section.

2. "Defendant" for purposes of sections 538.205 to 538.230 shall be defined as:

(1) A hospital as defined in chapter 197, RSMo, and its employees and physician employees who are insured under the hospital's professional liability insurance policy or the hospital's self-insurance maintained for professional liability purposes;

(2) A physician, including his or her nonphysician employees who are insured under the physician's professional liability insurance or under the physician's self-insurance maintained for professional liability purposes;

(3) Any other health care provider having the legal capacity to sue and be sued and who is not included in subdivisions (1) and (2) of this subsection, including employees of any health care providers who are insured under the health care provider's professional liability insurance policy or self-insurance maintained for professional liability purposes.

3. In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, where the trier of fact is a jury, such jury shall not be instructed by the court with respect to the limitation on an award of noneconomic damages, nor shall counsel for any party or any person providing testimony during such proceeding in any way inform the jury or potential jurors of such limitation.

4. The limitation on awards for noneconomic damages provided for in this section shall be increased or decreased on an annual basis effective January first of each year in accordance with the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. The current value of the limitation shall be calculated by the director of the department of insurance, who shall furnish that value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021, RSMo.

5. Any provision of law or court rule to the contrary notwithstanding, an award of punitive damages against a health care provider governed by the provisions of sections 538.205 to 538.230 shall be made only upon a showing by a plaintiff that the health care provider demonstrated willful, wanton or malicious misconduct with respect to his or her actions which are found to have injured or caused or contributed to cause the damages claimed in the petition.

538.211. 1. In all actions against a health care provider pursuant to this chapter, any health care defendant who has filed a timely motion to transfer venue may move for a hearing on the propriety of venue. All discovery shall be stayed except for discovery on the issue of venue raised in the motion. Within

ninety days of the filing of the motion, the court shall set a hearing on the motion.

2. If after hearing the court determines that venue is improper, the court shall transfer venue to a county where venue is proper.

3. The court may award reasonable costs, expenses, and attorneys' fees associated with said motion to the prevailing party.

538.225. 1. In any action against a health care provider for damages for personal injury or death on account of the rendering of or failure to render health care services, the plaintiff or **[**his**]** the plaintiff's attorney shall file an affidavit with the court stating that he or she has obtained the written opinion of a legally qualified health care provider which states that the defendant health care provider failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances and that such failure to use such reasonable care directly caused or directly contributed to cause the damages claimed in the petition.

2. **[**The affidavit shall state the qualifications of such health care providers to offer such opinion.**]** The health care provider who offers such opinion shall have education, training, and experience in a like area of expertise, or logical extension of the field of expertise, as the defendant health care provider. In addition, the health care provider must be actively engaged in

the practice of medicine or have retired from actively practicing within five years of the date of the written opinion. The written opinion is, upon motion of a party, subject to in-camera review by the court without counsel or the parties present to assure its compliance with this section.

3. A separate affidavit shall be filed for each defendant named in the petition.

4. Such affidavit shall be filed no later than ninety days after the filing of the petition unless the court, for good cause shown, orders that such time be extended.

5. If the plaintiff or **[**his**]** the plaintiff's attorney fails to file such affidavit **[**the court may**]** within the time required under subsection 4 of this section, the action as to that defendant shall be stayed and the court shall, upon motion of any party, dismiss the action against **[**such moving party**]** that defendant without prejudice.

538.226. 1. The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of or in addition to any of the above shall be admissible under this section.

2. As used in this section, "benevolent gestures" means actions which convey a sense of compassion or commiseration

emanating from humane impulses.

Section 1. 1. Any person may file a miscellaneous case for the purpose of securing copies of such person's health care records or the health care records of any other individual for whom such person is the guardian or attorney-in-fact, or is a potential claimant for a wrongful death.

2. A miscellaneous case shall be filed in the circuit in which any of the health care records sought to be obtained are located.

3. The petition shall be filed according to the following guidelines:

(1) The petition shall contain the following:

(a) The name of the individual who received the health care services or medical treatment;

(b) A brief summary of the health care services or medical treatment received;

(c) A brief summary of the outcome of the health care services or medical treatment; and

(d) The names of the health care providers from whom health care records are being sought;

(2) The petition shall not contain allegations of negligence or demands, other than a general demand for access to health care records.

4. Within five business days of filing the miscellaneous case, the petitioner shall mail a copy of the petition by regular

and certified mail to each health care provider listed in the petition. The petitioner shall certify to the court that the petition has been mailed as required.

5. After filing a miscellaneous case, the petitioner may request the health care records described in subsection 1 of this section by subpoena and, if necessary, subpoena the health care records custodian for a deposition for the sole purpose of securing copies of the health care records and verifying their authenticity. Refusal to provide the requested records may be the basis for the court to impose sanctions or orders of contempt.

6. Filing of a miscellaneous case petition shall toll the applicable statute of limitations for one hundred twenty days on any claim for injuries or death caused by professional negligence of a health care provider, but in no event shall the applicable statute of limitations be tolled under this section for more than one hundred twenty days.

7. The naming or listing of a health care provider as a person from whom records are requested shall not be considered for any reporting purposes as a claim made against the health care provider.

8. A health care provider or any person or entity acting on behalf of a health care provider shall not charge more than is allowable under section 197.227, RSMo, for providing copies of health care records.

Section B. Because immediate action is necessary to take action regarding the circumstances facing the medical malpractice liability insurance market in this state section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and section A of this act shall be in full force and effect upon its passage and approval.